Integrative Therapeutic Family Services/ Mobile Crisis Stabilization Services Referral Form

Child's Name: DOB:	//	Age:	Sex:
MA# SS#		_	
This child is currently residing (Check One): ☐ With biological p ☐ Foster Care ☐ Shelter Care ☐ Group Home ☐ RTC	parent(s) \square Wit	th another family	member
•			
Current caregiver of child:	Phone:		
Address:			
Referral Agency: Agency Contact Person: _			
Phone: () Email Address:			<u> </u>
Who has custody of the child?:P	hone:		
Who is the legal guardian of the child?:	Relatio	onship to Child:_	
Who can sign releases of information for this child?Phone: Email Address:			
Has the parent's parental rights been terminated? ☐ Yes What is the present Permanency Plan for this youth?	\square No		
Education:			
School Name:Contact:		Phone:	
Currently Enrolled: Yes No Current School Grade:	<u> </u>		
Current Medical Information:			
Name of Somatic Physician: Phon	e:		
Is the child receiving mental health services? Yes No			
Name of psychiatrist: Phon	e #:		
Name of therapist: Phone #	·		
Last Visit: Next scheduled appointment Has there been any known bed bug infestations in the home		2-3 months? [Yes No
Please include any information that would be helpful including a	ssessments, court	orders, custody	or guardianship papers, etc.
What brought this child/family to the attention of DSS?:			
*Individual Authorization Releases are attached. Please compleated referral. Blank Individual Authorization Releases provided be return signed documents with completed referral. A blank release included: Child's therapist, Child'spsychiatrist, Child's Primary (Board of Education, Mental Health System's Office, Child's Law working with (ex. Archway, DJS, Brooklane, etc.)	<mark>elow.</mark> Please comp e is also provided Care Physician, D	plete one for each for any other ser Department of So	h service checked below and rvices we may not have cial Services
		For ME	ISO (CSA) use only:
		ITFS:	
		MCSS:	

INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to conindividual's health information.	firm the direction of an individ	-	t, to use, or to disclose the
	s for psychotherapy notes. If the sype of health information. If the form must be submitted.	this authorization is for psychother e individual seeks to authorize the	rapy notes, DHMH will not use it use and disclosure of other health
Last Name:	First Name:	MI:	
Street Address:			
City:	State:	Zip: _	
Phone: (home) Section B: The use and/or Discle authorizing us to use and/or disc. The purpose of the disclosure (example)	close. To share, exchange, obta optional): Continuation and con	nin, disclose information. ntinuity of care	ealth information you are
Who is authorized to Receive/Di	sclose and Use your health in	<u>formation:</u>	
DHMH PROGRAM NAME(S): ADDRESS: P.O. Box 1745 Cumb			
TELEPHONE NUMBER: (301)	<u>759-5070</u>		
Who is authorized to Receive/Di	sclose and Use your health in	formation:	
NAME(S) Department of Social	Services ADDRESS (One Frederick St., Cumberland, M	D 21502
TELEPHONE NUMBER: 301-784-7000			
If the information which the progretation released under the Section C: Expiration and revocition FORM.)	is authorization.	· —	
Expiration: This authoriza	ation will expire (complete one)		
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA) . I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.			
Section D: Signature To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.			
Signature:	I	Date:	
If a personal representative is make following: Personal Representative's Name Relationship to Individual:	e:		egal authority and complete the

INDIVIDUAL'S AUTHORIZATION Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

individual's health information. Please type or print neatly; we are not able to process incomplete or illegible forms.			
Check if this authorization is as an authorization for any other information as well, an additional	s for psychotherapy notes. If this a type of health information. If the indi	authorization is for psychotherapy notes, DHMH will not use it ividual seeks to authorize the use and disclosure of other health	
Last Name:	First Name:	MI:	
Street Address:			
City:	State: _	Zip:	
Phone: (home)	(work)	DOB:	
authorizing us to use and/or dis .The purpose of the disclosure (close. To share, exchange, obtain, doptional): Continuation and continu	ity of care	
Who is authorized to Receive/D	isclose and Use your health inform	<u>iation:</u>	
DHMH PROGRAM NAME(S) ADDRESS: P.O. Box 1745 Cum	` '		
TELEPHONE NUMBER: (301	<u>) 759-5070</u>		
Who is authorized to Receive/D	isclose and Use your health inform	nation:	
NAME(S) Board of Education ADDRESS 108 Washington St., Cumberland, MD 21502			
TELEPHONE NUMBER: 301-759-2000			
If the information which the program has includes records or information from another entity, I do orX do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS			
Expiration: This authorization will expire (complete one): On// On occurrence of the following event (which must relate to the individual or to the			
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA) . I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.			
Section D: Signature To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.			
Signature:	Date:		
If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following: Personal Representative's Name: Relationship to Individual:			

(PRIMARY CARE PHYSICIAN) INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual's health information. Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure. First Name: City: State: Zip: Phone: (home) (work) DOB: Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose. To share, exchange, obtain, disclose information. .The purpose of the disclosure (optional): Continuation and continuity of care Who is authorized to Receive/Disclose and Use your health information: **DHMH PROGRAM NAME(S)**: MHSO (CSA) ADDRESS: P.O. Box 1745 Cumberland, MD 21502 **TELEPHONE NUMBER:** (301) 759-5070 Who is authorized to Receive/Disclose and Use your health information: NAME(S) ADDRESS TELEPHONE NUMBER: If the information which the program has includes records or information from another entity, I _ _ do or _X__ do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.) Expiration: This authorization will expire (complete one): On occurrence of the following event (which must relate to the individual or to the **Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA). I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation. **Section D: Signature** To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent. Date: _____ Signature: If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following: Personal Representative's Name:

Relationship to Individual:

(THERAPIST) INDIVIDUAL'S AUTHORIZATION

<u>Purpose</u>: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure. Last Name: ___ MI:___ Street Address: _____ City: State: Zip: Phone: (home) (work) _____ DOB: __ Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose. To share, exchange, obtain, disclose information. .The purpose of the disclosure (optional): Continuation and continuity of care Who is authorized to Receive/Disclose and Use your health information: **DHMH PROGRAM NAME(S)**: MHSO (CSA) ADDRESS: P.O. Box 1745 Cumberland, MD 21502 **TELEPHONE NUMBER**: (301) 759-5070 Who is authorized to Receive/Disclose and Use your health information: NAME(S) ADDRESS TELEPHONE NUMBER: If the information which the program has includes records or information from another entity, I __ do or _X__ do not wish to have that information released under this authorization. Section C: Expiration and revocation, (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.) Expiration: This authorization will expire (complete one): On occurrence of the following event (which must relate to the individual or to the Purpose of the use and/or disclosure being authorized): **Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA). I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation. **Section D: Signature** To the Individual - Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent. Signature: ____ Date: ____ If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

(PSYCHIATRIST) INDIVIDUAL'S AUTHORIZATION Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

individual's health information.				
	Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it			
as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health				
information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure.				
		and Disclosure.		
Last Name:	First Name:		MI:	
Street Address:	_			
City:	State: _	Zip: _		
Phone: (home)	(work)	DOB:		
Section B: The use and/or Disclosure b	eing authorized provide	a detailed description of the	health information you are	
authorizing us to use and/or disclose. The purpose of the disclosure (optional)				
.The purpose of the disclosure (options	ar): Continuation and conti	nuity of care		
Who is authorized to Receive/Disclose	and Use your health info	rmation:		
DHMH PROGRAM NAME(S): MHSO	O (CSA)			
ADDRESS: P.O. Box 1745 Cumberland				
TELEPHONE NUMBER : (301) 759-50	070			
TELETHONE NUMBER. (301) 739-30	<u>570</u>			
Who is authorized to Receive/Disclose	and Use your health info	rmation:		
NAME(S)	ADDRESS			
TELEPHONE NUMBER:				
	orization.	_	_	
On// On occurrence of the following	g event (which must relate	to the individual or to the		
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA) . I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.				
Section D: Signature To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.				
Signature:	Da	te:		
If a personal representative is making thi following: Personal Representative's Name:	s request, please attach a co		legal authority and complete the	

(LAWYER) INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

individual's health information. Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure. Last Name: MI: State: Phone: (home) (work) DOB: Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose. To share, exchange, obtain, disclose information. .The purpose of the disclosure (optional): Continuation and continuity of care Who is authorized to Receive/Disclose and Use your health information: **DHMH PROGRAM NAME(S)**: MHSO (CSA) ADDRESS: P.O. Box 1745 Cumberland, MD 21502 **TELEPHONE NUMBER:** (301) 759-5070 Who is authorized to Receive/Disclose and Use your health information: TELEPHONE NUMBER: If the information which the program has includes records or information from another entity, I _ _ do or _X__ do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.) This authorization will expire (complete one): Expiration: On occurrence of the following event (which must relate to the individual or to the Purpose of the use and/or disclosure being authorized): Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA). I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation. **Section D: Signature** To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent. Date: _____ If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following: Personal Representative's Name: Relationship to Individual:

(FOSTER PARENT) INDIVIDUAL'S AUTHORIZATION Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

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Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure.			
Last Name:	First Name:	MI:	
Street Address:			
City:	State:	Zip:	
Phone: (home) (work)			
Who is authorized to Receive/Dis	sclose and Use your health information:		
DHMH PROGRAM NAME(S): ADDRESS: P.O. Box 1745 Cumb	. ,		
TELEPHONE NUMBER: (301)	<u>759-5070</u>		
Who is authorized to Receive/Disclose and Use your health information:			
NAME(S) Department of Social Service Foster Parents ADDRESS One Frederick St. Cumberland, MD 21502			
TELEPHONE NUMBER: _ 301-784-7000			
If the information which the program has includes records or information from another entity, I do or _X do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.) Expiration: This authorization will expire (complete one): On / / On occurrence of the following event (which must relate to the individual or to the Purpose of the use and/or disclosure being authorized):			
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA) . I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.			
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Signature:	Date:		
If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following: Personal Representative's Name: Relationship to Individual:			

(ARCHWAY or OTHER PROGRAMS) INDIVIDUAL'S AUTHORIZATION

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Relationship to Individual:

(BROOKLANE or other HOSPITAL) INDIVIDUAL'S AUTHORIZATION

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Relationship to Individual:

(BLANK) INDIVIDUAL'S AUTHORIZATION Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual's health information.

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as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.			
	Information authorized for Use and Disclo	sure.	
Last Name:	First Name:	MI:	
Street Address:			
<u>City:</u>	State:	Zip: _	
Phone: (home)	(work)	DOB:	
	osure being authorized provide a detailed close. To share, exchange, obtain, disclose in	description of the health information you are nformation.	
.The purpose of the disclosure (optional): Continuation and continuity of car	re	
Who is authorized to Receive/D	isclose and Use your health information:		
DHMH PROGRAM NAME(S):	MHSO (CSA)		
ADDRESS: P.O. Box 1745 Cumb			
TELEPHONE NUMBER: (301)	759-5070		
Who is authorized to Receive/D	isclose and Use your health information:		
NAME(S)	ADDRESS		
TELEPHONE NUMBER:			
that information released under the Section C: Expiration and revoc FORM.)	is authorization.	n another entity, I do or _X do not wish to have IPLETED, DHMH CANNOT ACCEPT THIS	
	ollowing event (which must relate to the indivior disclosure being authorized):	vidual or to the	
In order to obtain a revocation for revocation of this authorization w		ne by giving written notice of my revocation to DHMH. that I may contact MHSO (CSA). I understand that s named or unnamed took in reliance on this	
Voluntary. I understand that if the the federal or state health informa	re of my health information as described in Separations or organizations I authorize to receition privacy laws, they might further disclosed in privacy laws. I have had full opportunity to	Section B above. I understand this authorization is ive and/or use my health information are not subject to the health information, and it may no longer be to read and consider the contents of this authorization,	
Signature:	Date:		
following:	cing this request, please attach a copy of any	document granting legal authority and complete the	